STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	R 03/07/2018

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SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS	{F 000}		

An unannounced Medicare/Medicaid revisit to the standard survey conducted 1/30/18 through 2/1/18, was conducted 3/6/18 through 3/7/18. No complaints were investigated. New findings are identified in the body of this report. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements.

The census in this 93 certified bed facility was 81 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents # 101 through 112).

F 641 SS=E Accuracy of Assessments
CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure accurate minimum data set (MDS) assessments for four of 12 residents in the survey sample. Bed rails used to assist with mobility and repositioning for Residents #101, #105, #107 and #108 were inaccurately coded on MDS assessments as physical restraints.

The findings include:

1. Bed rails used by Resident #107 for bed mobility and repositioning were inaccurately coded on the MDS as a physical restraint.

{F 000}

Shenandoah Valley Health and Rehab Facility is filing this Plan of Correction of purposes of regulatory compliance. The facility is submitting this Plan of Correction to comply with applicable law. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.

F 641

1. **Residents #101, #015, #107 and #108 remain in the facility. Applicable MDS' have been modified for proper side rail coding**
2. **Residents in the facility have the potential for inaccurate coding of side rails.**
3. **Re-education will be provided by the VP of Clinical Reimbursement /designee to the MDS Coordinator and assistant on appropriate coding of side rails. DNS/designee will do weekly audits of the MDS following the routine care plan schedule to validate the accuracy of coding of the side rails over the next three months.**
4. **Results of the audits will be taken to the monthly/quarterly Quality Assurance Performance Improvement for review and re-education will be provided as needed.**
5. **Corrective action will be completed on March 15, 2018**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Janette Coleman	Administrator	March 13, 2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Resident #107 was admitted to the facility on 3/9/17 with diagnoses that included pneumonia, schizoaffective disorder, dementia, high blood pressure and asthma. The minimum data set (MDS) dated 2/13/18 assessed Resident #107 with moderately impaired cognitive skills. Section P. of this MDS, completed in response to a significant change in status, listed bed rails as a physical restraint used daily by the resident.

On 3/6/18 at 1:05 p.m., Resident #107 was observed in bed with half-length bed rails in the up position near the head of the bed. Resident #107 was interviewed at this time about her bed rails. Resident #107 stated she used the rails to reposition in bed and the bed rails were tightly secured to her bed.

Resident #107's clinical record and plan of care documented no assessment indicating use of physical restraints or of any condition treated or addressed with a physical restraint. The clinical record documented a side rail assessment dated 2/23/18. This assessment documented half-length side rails were recommended to provide safety for the resident and stated, "Side Rails are Indicated and Serve as an Enabler to Promote Independence."

Resident #107's clinical record documented a physician's order dated 3/9/17 for, "Assist rails to aid in bed mobility and positioning." Resident #107's plan of care (revised 2/15/18) listed the resident had self-care deficits due to impaired physical abilities. Interventions to maintain physical functioning included, "Assist rails to bed to aid in mobility and positioning." The care plan made no mention of any physical restraints in use

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F 641	Continued From page 2	F 641		

with Resident #107.

On 3/6/18 at 3:00 p.m., the administrator and director of nursing (DON) were interviewed about Resident #107's bed rails coded as a physical restraint on the MDS. The DON stated all the side rails in the facility were coded as physical restraints. When asked why the bed rails were considered a restraint, the DON stated their upper management told the facility to code any side rail in use as a physical restraint. When asked how the bed rails physically restrained Resident #107, the DON state she did not think the rails restrained Resident #107. The DON stated she was told by "higher ups" that if bed rails were used they were considered a restraint and referenced the RAI (Resident Assessment Instrument) manual. The administrator also stated she had been told by upper management to code any bed rails in use as a physical restraint. The DON offered no rationale for how or why Resident #107's side rail use met the definition of a physical restraint.

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual documents on page P-1 concerning section P. for restraints, "The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definition in the appropriate categories... Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices,

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material or equipment as physical restraints... While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule..." Page P-5 of this reference states, "In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use..." This manual on page P-1 lists the definition of a physical restraint as, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP)." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 3/6/18 at 3:00 p.m. and on 3/7/18 at 9:50 a.m.

2. Bed rails used by Resident #108 for bed mobility and repositioning were inaccurately coded on the MDS as a physical restraint.

Resident #108 was admitted to the facility on 12/15/17 with diagnoses that included depression, hypothyroidism, urinary tract infection and degenerative nerve disorder. The minimum data set (MDS) dated 2/15/18 assessed Resident #108 as cognitively intact. Section P. of this MDS listed bed rails as a physical restraint used daily by the resident.

On 3/6/18 at 1:15 p.m., Resident #108 was observed in her wheelchair in her room. The

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resident's bed had 1/4 length side rails in place in the lowered position near the head of the bed. Resident #108 was interviewed at this time about the use of the bed rails. Resident #108 stated she used the bed rails when moving about in bed and when pulling up to sit on the bedside.

Resident #108's clinical record documented an admission assessment form dated 12/15/17 that include an assessment regarding bed rail use. This assessment recommended use of half-length bed rails for Resident #108 and stated, "Side Rails are Indicated and Serve as an Enabler to Promote Independence."

The record documented a physician's order dated 12/15/17 for, "Assist rails to aid in bed mobility and positioning." The resident's plan of care (revised 1/22/18) listed the resident had self-care deficits related to impaired mobility and degenerative neuromuscular disease. Interventions to improve and/or maintain physical functioning included, "Assist rails to bed to aid in mobility and positioning..."

There was no assessment or mention in the clinical record documenting any need or condition addressed with use of a physical restraint for Resident #108.

On 3/6/18 at 3:00 p.m., the administrator and director of nursing (DON) were interviewed about Resident #108's bed rails coded as a physical restraint on the MDS. The DON stated all the side rails in the facility were coded as physical restraints. When asked why the bed rails were considered a restraint, the DON stated their upper management told the facility to code any side rail in use as a physical restraint. When

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asked how the bed rails physically restrained Resident #108, the DON state she did not think the rails restrained Resident #108. The DON stated she was told by "higher ups" that if bed rails were used they were considered a restraint and referenced the RAI (Resident Assessment Instrument) manual. The administrator also stated she had been told by upper management to code any bed rails in use as a physical restraint. The DON offered no rationale for how or why Resident #108's bed rail use met the definition of a physical restraint.

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual documents on page P-1 concerning section P. for restraints, "The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definition in the appropriate categories... Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, material or equipment as physical restraints... While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule..." Page P-5 of this reference states, "In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use..." This manual on page P-1 lists the definition of a physical restraint as, "Any manual method or

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physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP)." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 3/6/18 at 3:00 p.m. and on 3/7/18 at 9:50 a.m.

(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.15, Centers for Medicare & Medicaid Services, Revised October 2017.

3. Resident # 101's most recent Minimum Data Set failed to accurately reflect the resident's use of siderails as an assistive device.

Resident # 101 in the survey sample, a 78 year-old female, was admitted to the facility on 12/26/17 with diagnoses that included anemia, hypertension, hyperlipidemia, protein malnutrition, depression, generalized muscle weakness, a Stage IV sacral pressure ulcer, and osteomyelitis. According to a Medicare 30-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/23/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 our of 15.

Under Section P (Restraints), at Item P0100 Physical Restraints, the resident was assessed as using bed rails daily. Section P also includes the following definition of physical restraints, "Physical restraints are any manual method or

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F 641	Continued From page 7	F 641		

physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."

Resident # 101 had the following physician's order, dated 12/27/17, "Assist rails to bed to aid in mobility and positioning."

An Admission Data Collection Form, dated 12/26/17, included the following: "Recommendation: Side rails are indicated and serve as and enabler to promote independence."

Resident # 101's care plan, dated 1/3/18, included the following problem, "I have a physical functioning deficit related to: Mobility impairment, ROM (Range of Motion) limitations, self-care impairment." The goal for the problem was, "I will improve my current level of physical functioning over the next 90 days."

Included as an intervention to the stated problem was the following, "Assistive devices: bed side rails to assist with bed mobility and repositioning."

The discrepancy between the MDS assessment of the side rails as a restraint, and the physician's order, the resident's care plan, and the Admission Data was discussed during a meeting with the facility's administrative staff and the survey team at 9:50 a.m. on 3/7/18.

4. Resident # 105's most recent Minimum Data Set failed to accurately reflect the resident's use of siderails as an assistive device.

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F 641	Continued From page 8	F 641		

Resident # 105 in the survey sample, an 83 year-old female, was admitted to the facility on 1/15/13, and readmitted on 9/22/14, with diagnoses that included diabetes mellitus, cardiovascular disease, Non-Alzheimer's Dementia, Parkinson's Disease, anxiety disorder, depression, acute kidney failure, and spinal stenosis. According to a Quarterly MDS with an ARD of 1/124/18, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

Under Section P (Restraints), at Item P0100 Physical Restraints, the resident was assessed as using bed rails daily.

Resident # 105 had the following physician's order, dated 9/23/14, "Assist rails to bed to aid in mobility and positioning."

A Quarterly Data Collection Form, dated 1/18/18, included the following: "Recommendation: At this time side rails are indicated to provide safety."

Resident # 105's care plan, dated 9/22/14, included the following problem, "I have a physical functioning deficit related to self-care and mobility impairment...." The goal for the problem was, "I will improve my current level of physical functioning with therapy over the next 90 days."

Included as an intervention to the stated problem was the following, "Assistive devices - assist rails for improved mobility and functioning."

The discrepancy between the MDS assessment of the side rails as a restraint, and the physician's order, the resident's care plan, and the Admission

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F 641	Continued From page 9 Data was discussed during a meeting with the facility's administrative staff and the survey team at 9:50 a.m. on 3/7/18.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of quality during medication administration for one of 12 residents in the survey sample. Resident #112 was administered two puffs of the inhalant medication Advair instead of one puff as ordered by the physician. The Advair was not shaken prior to administration and Resident #112 was not prompted to rinse and spit following the administration of Advair as recommended by the manufacturer. The findings include: Resident #112 was admitted to the facility on 12/21/17 with diagnoses that included status post joint replacement, COPD (chronic obstructive pulmonary disease), high blood pressure and diabetes. The minimum data set (MDS) dated 2/15/18 assessed Resident #112 as cognitively intact. A medication pass observation was conducted on 3/7/18 at 8:10 a.m. with licensed practical nurse	F 658	**1. Resident #112 remains in the facility. Physician was notified of the failure to follow professional standards of quality during medication administration of the Advair inhalant. Resident without adverse outcome. Identified nurse and re-education on medication administration of the Advair inhalant was completed.** **2. Residents receiving Advair could have the potential of being affected by this deficient practice.** **3. Licensed nurses will be re-educated on the administration of Advair. DNS/designee will conduct medication pass observation weekly to assure Advair is being administered per manufacturer recommendation over the next three months.** **4. Results of audits will be taken to Quality Assurance Performance Improvement for review and recommendations for three months with Quality Assurance Performance Improvement committee responsible for ongoing compliance.** **5. Corrective action will be completed by March 15, 2018.**	

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(LPN #1) administering medications to Resident #112. During this observation, LPN #1 administered the medication Advair 250-50 mcg (micrograms) to Resident #112 with use of an inhaler device. LPN #1 did not shake the Advair diskus prior to administration. Resident #112 inhaled two puffs from the Advair diskus inhaler device. The resident did not rinse his mouth and spit out the rinse following the Advair administration. LPN #1 did not prompt the resident to inhale only one puff and did not instruct the resident to rinse and spit following the administration.

Resident #112's clinical record documented a physician's order dated 12/21/17 for Advair diskus (Fluticasone-Salmeterol Aerosol Powder Breath Activated) 250-50 mcg/dose 1 puff to be inhaled orally every 12 hours for treatment of COPD.

On 3/7/18 at 8:45 a.m., LPN #1 was interviewed about the Advair administration to Resident #112. LPN #1 stated she tried to tell the resident to take one puff but the resident "does what he wants." LPN #1 stated the resident usually refuses to rinse and spit. LPN #1 acknowledged she did not prompt or remind the resident to rinse and spit after inhaling the medication.

Manufacturer instructions listed on the Advair diskus box stated, "After each dose, rinse your mouth with water and spit it out. Do not swallow water."

The facility's medication reference book titled PharMerica 2014 Specialized Long-term Care Nursing Drug Handbook on page 553 described Advair as a corticosteroid inhalant used for maintenance treatment of asthma and COPD.

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F 658	Continued From page 11 Administration instructions stated to shake the diskus well for 5 seconds before each spray and to rinse mouth with water after use and spit to reduce risk of oral candidiasis. (1) These findings were reviewed with the administrator and director of nursing during a meeting on 3/7/18 at 9:50 a.m. (1) Glen, Henry. PharMerica 2014 Specialized Long-Term Care Nursing Drug Handbook. Philadelphia: Wolters Kluwer Health, 2013.	F 658		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	**1. LPN #1 remains in the facility. LPN #1 was re-educated on day of survey in reference to proper hand washing during a medication pass. Licensed Nurse #1 verbalized back to the DNS that she should have sanitized or washed her hands between administering medications to each resident. LPN #1 verbalized the importance of sanitizing or washing hands upon exiting every resident's room.** **2. Residents have the potential to be affected by this deficient practice. DNS/Designee will do random hand washing observations every week to validate compliance.** **3. Re-education will be provided to licensed nursing staff on the process of proper hand washing and sanitation during medication pass.** **4. DNS/designee will do random hand washing observations during medication pass every week to validate compliance.** **5. Corrective action will be completed by March 15, 2018.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	R 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880		

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.

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F 880	Continued From page 13	F 880		

The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to follow infection control practices for hand hygiene. A nurse failed to perform hand hygiene between residents during a medication pass observation.

The findings include:

A medication pass observation was conducted on 3/7/18 from 7:50 a.m. through 8:10 a.m. Licensed practical nurse (LPN) #1 was observed administering medications during this time to four residents.

On 3/7/18 at 7:50 a.m., LPN #1 administered an insulin injection to the first resident in the medication pass. Without performing hand hygiene, LPN #1 prepared and administered medications to the next resident. On 3/7/18 at 8:05 a.m., LPN #1 prepared and administered medications to the third resident in the pass. Without performing hand hygiene, LPN #1 prepared and administered medications, including nose spray and an inhalant, to the fourth resident in the pass.

On 3/7/18 at 8:30 a.m., LPN #1 was interviewed about hand hygiene between residents during the observed medication pass. LPN #1 stated she usually performed hand hygiene between residents. LPN #1 stated hand hygiene was supposed to be performed between residents.

The facility's policy titled Hand Washing Technique (effective 2/17) documented, "All

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F 880	Continued From page 14	F 880		

personnel will wash hands before beginning the treatment/care of a resident and upon completion of such tasks, to prevent the spread of nosocomial infections. Wash hands after removal of gloves or other personal protective barrier equipment."

The facility's policy titled Administration Procedures for All Medications (revised August 2014) stated, "When finished with each resident, wash hand with antimicrobial soap and water or use facility-approved hand sanitizer."

These findings were reviewed with the administrator and director of nursing during a meeting on 3/7/18 at 9:50 a.m.